STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL & DEVELOPMENTAL DISABILITIES

NEW PROVIDER APPLICATION FOR LONG TERM SERVICES – PART 2

Instructions: This application must be completed by any entity (e.g., individual, group, agency, or other type of organization) seeking to be a new provider of services administered by the Department of Intellectual and Developmental Disabilities (DIDD).

All questions and correspondence regarding the New Provider Application should be directed to:
Provider Enrollment Coordinator
Department of Intellectual and Developmental Disabilities
E-mail: DIDDProvider.Application@tn.gov
Phone: (615) 532-6530

Process Overview: The process for completing a Long Term Application (LTA) includes the steps listed below. Refer to the 80.1.1 New Provider Application Policy for additional details regarding completing the application process.

- The Office of DIDD Provider Development will announce Open Enrollment and/or Targeted Enrollment on the DIDD Web Site. http://www.tn.gov/didd/
- Applicants submit a completed New Provider Initial Screening Questionnaire-Part 1, which is the first part of the Long Term Application Process.
- Upon approval of the New Provider Initial Screening Questionnaire-Part 1 by DIDD, applicants will be invited to the New Provider Pre-Application Activity.
- After attending the New Provider Pre-Application Activity, applicants will submit the completed New Provider Application for Long Term Services-Part 2 or Support Coordination- Part 2, which is the second part of the Long Term Application Process.
- Applicants who are not approved to register for **New Provider Pre-application Activity** (e.g. the New Provider Initial Screening Questionnaire-Part 1 was not approved) must wait until the next open and/or targeted enrollment period for identified services before submitting another Questionnaire/Application to DIDD.

Applicable Services: The Long Term Application (LTA) shall apply to the following services:

Community-Based Day	Facility-Based Day
Supported Employment	In-Home Day
Respite	Behavioral Respite
Intensive Behavior Residential (IBRS) *	Personal Assistance
Medical Residential	Supported Living
Residential Habilitation	Family Model Residential Support
Semi Independent Living	Individual Transportation for Respite and Personal Assistance
Support Coordination	

*See IBRS Requirements

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Medicaid Home and Community Based Services Waivers

Date Application Submitted: _____

ORGANIZATIONAL INFORMATION

Name of Business _____

Doing Business As (*if different from above*) _____Region_____

Have there been any changes to owner, non-profit organization board member, or the executive director since the submission of the Initial Screening Questionnaire? No: _ _____ Yes: _____

If yes, you must wait till the next announced Open/Targeted Enrollment Process.

WAIVER SERVICES **Day, Respite Residential and Individual Transportation**	**REQUESTED REGIONS**		
	W	M	E
Day: Community-Based Day (CB)			
Day: Facility-Based Day			
Day: Supported Employment (SE)			
Day: In-Home Day			
Respite (R)			
Residential: Behavioral Respite			
Residential: Intensive Behavior Residential			
Residential: Family Model Residential Support			
Residential: Medical Residential (MR)			
Residential: Personal Assistance (PA)			
Residential: Residential Habilitation (RH)			
Residential: Supported Living (SL)			
Residential: Semi Independent Living			
Individual Transportation for Respite and Personal Assistance service			

1. Based on your organizational chart, submit a Business Plan addressing the following areas as an attachment to the New Provider Application.

A. Organizational Capacity		**Mark each item as completed**
1.	By-laws of the organization that outline the makeup, meeting frequency and activities of the Board of Directors or Advisory Board.	
2.	Job descriptions with education and other qualification for all positions listed on the organizational chart. Job descriptions must include pertinent duties to support DIDD requirements.	
3.	Describe the type of service(s) you are applying for that is consistent withTennessee DIDD waiver service definitions.	
4.	Submit resumes for the person (s) identified to manage the representative payee and personal funds for Residential, Day and Residential Habilitation services (Explain if not applicable). Include in resume, all professional management experience supporting persons who have an Intellectual/ developmental disability/other disability.	
B. Financial Capacity		
5.	Forecast income statement based on the current DIDD rate structure for the first two years of operation.	
6.	Budget: Attach a 12-month pro-forma (projected) operating budget which includes all income with specified sources and all identified expenses. The expenses include things such as: employee salaries and other employee costs, facility costs, utilities, transportation, service contracts, administrative cost, other support services, etc. Additionally, identify and project all revenue sources based on the numbers of individuals to be supported, the Medicaid reimbursement rates for the type services requested as well as any other income such as SSI for residential services.	
7.	Formal documentation of the owner's personal funds approved and provided by a state or federally chartered lending institution, equivalent to 6 (six) months of projected expenditures per the pro forma budget . The owner's personal finances must be in the name of the provider agency. The owner's personal finances must be officially documented by the lending institution; be maintained at all times during the qualification process and during actual provision of services and must be verifiable by DIDD at any time.	
8.	Documentation of registration with Tennessee Secretary of State authorizing the organization to conduct business.	

C. Required Policies – attach copies	**List name of Agency's corresponding policy**
1. Procedures for hiring staff, including minimum qualifications for each staff position.	
2. Job descriptions for each staff position.	
3. Procedures for initiating and resolving employee complaints or grievances.	
4. Requirements pertaining to use of employee-owned vehicles to transport people receiving services, if applicable.	
5. Procedures for progressive employee disciplinary actions, including, but not limited to sanctions for Title VI non-compliance, drug-free workplace violations, and substantiation for abuse, neglect or exploitation of people using services.	
6. Procedures for tuberculosis testing in accordance with current DOH policy.	
7. Procedures for maintaining a drug-free workplace.	

8. Showing respect to people using services at all times.	
9. Protecting and promoting the rights of people using services.	
10. Using positive behavior approaches with people using services, including prohibited interventions.	
11. Facilitating and supporting natural support systems.	
12. Obtaining necessary emergency and/or urgent health care for people using services.	
13. Addressing the health care needs of people using services, as specified in the individual transition plan (ITP) or ISP.	
14. Advocacy for the person supported and arranging for external advocacy services as needed.	
15. Taking appropriate action in emergency situations to ensure the safety of persons supported.	
16. Maintaining a sanitary and safe environment, including fire safety precautions in provider offices, individual homes and other sites where services are delivered.	
17. Managing and accounting for personal funds of people using services	
18. Maintaining a well-trained workforce.	
19. Managing and reporting incidents.	
20. Maintaining Title VI compliance.	
21. Providing services to individuals with Limited English Proficiency (LEP).	
22. Maintaining and monitoring of client the records of persons supported, including compliance with confidentiality requirements set forth in T.C.A. § 33-3-103 and HIPAA standards.	
23. Quality assessment, assurance and improvement.	
24. Protection from and prevention of harm.	
25. Maintaining personnel records for staff and sub-contractors, including evidence of timely completion of required checks that are listed in **Section 10.13.a. Employee Records:** e.g., background checks, DOH's Tennessee Elderly and Vulnerable Abuse Registry, the Sexual Offender Registry, and the Office of Inspector General's List of Excluded Individuals/Entities.	
26. Quality Assurance Plan	
27. Crisis Intervention Policy	

CERTIFICATION

I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should investigation show any falsification, my organization will not be considered as a potential provider of DIDD services. I hereby authorize the State of Tennessee to make all necessary investigations concerning the applicant. I further authorize and request each former employer, educational institution, or organization (including law enforcement agencies) to provide all information that may be sought in connection with this application.

The agency will carry adequate and appropriate general liability, professional liability, and workers compensation insurance for the protection of clients, staff, facilities, and the general public

Signature	Date
Title	Organization

STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

STATEMENT OF UNDERSTANDING

AGENCY NAME: _____

Is a principal of the agency a conservator for someone the agency intends to support?

Yes ❒ No ❒

If yes, complete the STATEMENT OF UNDERSTANDING:

The conservator will not receive payment as an employee or board member if their ward is supported by the organization unless specifically permitted in the Order of Conservatorship.

As parents of a minor child, or a spouse of a Medicaid Waiver service recipient, I hereby acknowledge I/we are aware that under Federal guidelines I/we cannot be paid as an employee or board member for services provided and funded under the Medicaid Home and Community Based Services Waiver program. DIDD will monitor compliance to this federal statute. Consequences for non-compliance would include recoupment of funds used to pay the noted relatives, possible investigation of Medicaid fraud and disenrollment as a provider.

Print Name _____ **Relation:** _____

Signature: _____ **Date:** _____

Print Name _____ **Relation:** _____

Signature: _____ **Date:** _____

Print Name _____ **Relation:** _____

Signature: _____ **Date:** _____